Client Name______________________
Client ID#__________________

1195–Informed Consent for Outpatient Services

SERVICES: I understand that all services are voluntary. I have the right to be informed about services, to participate in their selection, and to withdraw this consent at any time, except to the extent that action has already been taken. Services include assessment, and may also include individual, group, family, and multifamily counseling, case management, medication management, crisis intervention, recreational and vocational therapy, parent education, and independent living skills. Acceptance and participation in these services shall not be considered a prerequisite for access to other community or county services. I have the right to request a change of provider, staff person, therapist, and/or case manager.

CONFIDENTIALITY: I understand that my relationship with Humboldt County Department of Health and Human Services - Behavioral Health is confidential unless I give permission to release information to a specific source, except in certain life and death emergencies or by court order. I also understand that if a staff person reasonably believes that I intend to harm others or myself, they are legally obligated to take steps to protect those at risk. In instances where a staff person reasonably suspects abuse or neglect of a child, elderly person or someone who is a dependent adult, they are mandated to report this information to the appropriate authorities.

CONTRACT FOR SERVICES: I understand that I am responsible for cooperating with my clinician/case manager, and for keeping my appointments or calling to cancel them in a timely manner. I understand that if I am more than ten minutes late for an appointment, I may not be seen that day. I also understand that if I fail to follow through or participate with treatment, my services may be terminated.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND GIVE MY CONSENT FOR TREATMENT. Unless I withdraw my consent earlier, this consent will expire one year from the date of my signature. I have the right to receive a copy of this document. I reserve all rights provided to me by law not waived by the scope of this consent and authorization. . If I am signing for a minor client, I attest that I am the legal guardian of said minor and have the right to authorize consent for treatment on their behalf.

____ ____________
Client Signature Date

____ ____________
Client/Guardian Signature Date

____ ____________
Staff Signature Date